BSE linked to new variant of CJD in humans

GAMMA/FSP

Taking care with cows' brains

Children are no more susceptible to the new variant of Creutzfeldt-Jakob disease than the rest of the population, the British government announced this week (see pages 790, 791, and 854). The Spongiform Encephalopathy Advisory Committee considered further genetic information on the 10 new cases of CJD reported last week and consulted with a paediatrician, immunologist, and gastroenterologist before reaching its decision last weekend. It repeated its view that the most likely explanation for the 10 new cases is exposure to the agent that causes bovine spongiform encephalopathy in cattle that occurred before the ban on the use of cow offal was introduced in 1989. In accepting the committee's opinion, the government has for the first time acknowledged that BSE could be transmissible to humans.

There were 40 cases of CJD in Britain last year according to government statistics, compared with 54 in 1994. About 15% of these have a genetic basis; others are sporadic, for which no cause is known—these usually occur in people aged over 60. Some people are still presenting with CJD after having been infected with contaminated growth hormone manufactured from human pituitary glands.

The alarm generated by the new cases is due to the age of the people affected, the similarity of their clinical presentations, and the neuropathological findings on postmortem examination. Eight of the 10 people have died. A further two suspected cases were announced by the advisory committee this week but have not been confirmed.

"The average age of these cases was 27," said Dr Robert Will, head of the National CJD Surveillance Unit in Edinburgh. "The duration of their illnesses was more prolonged, with an average duration of 13 months compared with a mean in other types of six months. They all tended to present with anxiety, depression, and behavioural problems and within weeks or months developed unsteadiness, ataxia, and dementia. They had atypical electroencephalograms that were different from those found in sporadic cases."

Dr Will said that the cases shared consistent patterns of pathology, with large aggregates of prion protein in their brains that were far higher than those found in sporadic disease. Dr James Ironside, a neuropathologist at the CJD surveillance unit, said that the distribution of prion protein differed from that in BSE in that it was concentrated more in the cerebellum and basal ganglia than in the brain stem.

Six of the people affected with the disease started having symptoms in 1994 and four in 1995. None of them had worked in the farming industry, and the Spongiform Encephalopathy Advisory Committee said that no genetic link had been found. The committee said that it would expect the incubation period of this variant of CJD to be between five and 10 years.

"There may be some other factor in the mid-1980s that occurred to explain these cases and we don't know about it, but we can't think what it could be," said Professor John Pattison, chairman of the committee. "It drives us inevitably to the conclusion that the most likely risk factor is exposure to BSE."

Tests could take two years

Tests to establish whether the transmissible agent is related to BSE are being done through strain typing of necropsy material and could take up to two years. The BSE phenotype is thought to be identifiable in humans because it remains stable when it passes through other species.

The advisory committee has refused to put any figures on the numbers of people who could be affected by the new variant of CJD. It emphasises that it cannot confirm that BSE is responsible for the new cases and that if it is there are still no data on the dose needed for infectivity and the magnitude of any species barrier that should theoretically limit transmission from cattle to humans.

Dr Rosalind Ridley, head of the MRC comparative cognition team at the School of Clinical Veterinary Medicine in Cambridge, said that no one could predict whether there will be an epidemic of the disease. "Within 12 months we will know the answer. Either we will have more cases or we won't."

The initial concern that children might be more at risk of the disease than adults was largely based on the experience of kuru, a spongiform encephalopathy that was prevalent in Papua New Guinea until cannibalism was banned.

Kuru was transmitted through the ritual practice of mainly mothers and their children eating the brains of cadavers. Since young children were affected by the disease it was thought that the incubation time for CJD could be shorter than it was in adults. But in Britain the Spongiform Encephalopathy Advisory Committee maintains that the new variant of CJD has so far not shown this characteristic and that in the 10 people identified with the disease infection occurred mostly in early adulthood.

BSE was first identified in British cows in 1986 and is thought to have been caused by feeding them protein derived from sheep infected with scrapie in the form of meat and bone meal. This practice was banned in 1988.—LUISA DILLNER, *BMJ*

Headlines

UK teenagers drink more alcohol: The proportion of young teenagers who drink alcohol every week has risen in the past four years, but 40% do not drink at all, according to a report from the Office of Population Censuses and Surveys. The alcohol of choice was beer, lager, or cider, followed by wine in England and Wales and spirits in Scotland.

US Senate overturns ruling on HIV test: The US Senate has overturned a law that requires the mandatory discharge of members of the armed forces in whom an HIV test yields a positive result. There is likely to be stiffer opposition to overturning the law in the House of Representatives.

Baby born to raped coma victim: An American woman who has been in a coma for 10 years has given birth to a baby after being raped in hospital. The baby, who was born nine weeks prematurely, was delivered normally. The case has caused an ethical outcry in the United States.

German health system in deficit: Germany's health insurance system ended in a deficit of DM7bn (£3.1bn; $4.7bn) in 1995 after a surplus of DM2.4bn (£1bn; $1.5bn) in 1994. The health minister has warned that contributions from employers and employees may have to be increased.

US tobacco industry might try to end claims: The chief executive of RJR Nabisco, the second biggest US tobacco group, has said that the industry might consider signing a legal and financial deal that settled antismoking claims for ever it if guaranteed immunity from litigation.

WHO warns of serious health conditions in Iraq: The WHO warned this week that health conditions in Iraq are deteriorating rapidly, with deaths of children under 5 increasing by more than 60% from 1990 to 1994. Infant mortality in Baghdad has doubled over the same period.

Death rate from breast cancer is falling: The death rates from breast cancer in Europe and North America are falling, says a report from the Imperial Cancer Research Fund in the *British Journal of Cancer*. The scientists say that earlier and better treatment and changes in childbearing patterns may be responsible.

WHO steps up fight against TB

Deaths from tuberculosis rose to three million in 1995—more than at any other time in history, including the epidemic of the early 1900s. The World Health Organisation warned last week that at current levels there could be an annual rate of death from the disease of five million within the next 50 years.

The WHO, in a report on the current epidemic, states that one third of the world's population—nearly two billion people—have already become infected with tuberculosis. It adds: "In the next ten years, 90 million people are expected to become sick with TB."

The WHO estimates that by the end of this decade cases of tuberculosis will have reached 17·9 million in South East Asia alone and 420 000 in western Europe; developed countries, it emphasises, are not immune.

In 1993 the WHO declared a global tuberculosis emergency and endorsed a strategy known as "directly observed treatment, shortcourse" (DOTS). The strategy involves health care workers or responsible family members watching patients take each dose of medicine for the first two months or, ideally, for the whole six months of treatment.

Dr Arata Kochi, director of the global programme, said that DOTS currently covered only about 10% of the world's population. Countries in which it operates include China (where half the population has been covered), Tanzania, and what Dr Kochi called "the fourth world slums of New York City." The DOTS strategy is able to cure nearly 95% of all patients—twice as many as any previous antituberculosis strategy.

Tuberculosis infection has increased for several reasons, according to Dr Kochi. "In developing countries people are made well enough to go home but then spread the bacillus," he said. This leads to an increase in drug resistance, particularly in those areas not using the DOTS strategy.

Other reasons for the increase in the spread of the disease include the susceptibility of patients infected with HIV. The WHO figures show that in the sub-Saharan regions of Africa one in three patients with AIDS is dying of tuberculosis and 35% of all patients with tuberculosis are HIV positive

Recent political upheavals around the world have increased the number of refugees. The WHO believes that 50% of all refugees may be infected with tuberculosis. The increase in air travel was cited as a further reason for the disease's spread.

Dr John Moore-Gillon, chairman of the British Lung Foundation, said: "Some respiratory physicians in London have reported an increase in tuberculosis of 50% since 1987, something I would never have predicted in my lifetime."—PRITPAL S TAMBER, *Clegg scholar, BMJ*

AIDS now more chronic than fatal

America's experts on AIDS are recommending that the disease should be classified as chronic rather than fatal and that research priorities should change to reflect this shift. A recent report reflecting the opinions of 118 scientists from government, industry, and academic institutions recommends major changes in the AIDS research agenda of the National Institutes of Health (NIH), which support about 85% of AIDS research worldwide.

The group commended the NIH for their first 15 years of work, which, it said, had removed the disease from the "fatal" category and added it to the "chronic" group. But it said that the money now distributed among the 24 institutes—$1·4bn (£920m) last year—could be better spent.

The group recommended that the NIH's Office of AIDS Research should be in charge

RON GILLING/PANOS

TB is transmissible by plane

of coordinating research. Two areas were cited as needing particular coordination and unification: clinical trials and vaccine development. More than a dozen institutes and agencies now run clinical trials involving AIDS, and the scientists recommended that they should all be placed under one roof at the National Institute for Allergy and Infectious Diseases.—JOHN ROBERTS, *North American editor, BMJ*

Gulf war veterans show nerve damage

A study of Gulf war veterans suffering from unexplained illness has found that some have evidence of nerve damage. Researchers from the Institute of Neurological Sciences at Glasgow's Southern General Hospital randomly selected 14 veterans from a list of those with unexplained illness and compared their responses to a range of neurological tests with those of 13 civilian controls matched for age, sex, handedness, and physical activity. Tests included heat, cold, and vibration sensibilities and motor and sensory nerve conduction on the arms and legs.

The veterans had abnormal responses in three peripheral nerve functions: cold threshold, sural nerve latency, and median nerve sensory action potential. Dr Goran Jamal, who led the study, published in the current issue of the *Journal of Neurology, Neurosurgery, and Psychiatry,* says that further tests are needed to confirm the dysfunction.

The British government has moved closer to the more sympathetic position of the US administration in acknowledging the possibility of a Gulf war syndrome. In January the Ministry of Defence commissioned its own independent studies, which will be overseen by the Medical Research Council. About 350 sick veterans have already been seen, and studies are to be carried out into birth defects in veterans' families.

Soldiers in the Gulf were given vaccines against a range of diseases and prescribed tablets containing pyridostigmine bromide and pentavalent botulinum toxoid to protect them against the potential use of chemical and biological weapons.—OWEN DYER, *freelance journalist, London*

Baby's doctors to ask for right to die

Doctors caring for a 3 month old baby girl who is severely brain damaged are to ask the High Court to let them switch off the ventilator keeping her alive. Sir Stephen Brown, president of the High Court's family division, who is expected to hear the case in May, will be asked to lay down guidelines for doctors taking decisions about withdrawing or withholding treatment from newborn babies with brain damage.

In the wake of a series of right to die cases involving adults, doctors are uncertain when such cases need to go to court and when they can take decisions themselves after consulting the baby's parents. If all the cases went to court, paediatricians estimate the High Court could be faced with 1000 cases a year. Unlike most cases involving children, this case will be heard in open court because of its public interest.

The baby, from the north of England, is a ward of court and cannot be identified. Born nine weeks prematurely, she is prone to fits and is thought to be blind and deaf. Doctors believe she suffers pain and distress when the tube connecting her to the ventilator has to be sucked out to stop it blocking up.

The case follows the death from natural causes of Thomas Creedon, the 2 year old boy with brain damage whose parents were planning to ask the court to allow him to die, a move opposed by his doctors. Lawyers believe that that case, the first to seek court sanction for the withdrawal of feeding from a patient not in the persistent vegetative state, had no chance of success. A BMA spokesman said: "In the light of recent cases, doctors accept that the courts should play a part in cases like this, in setting clear parameters for doctors dealing with these cases. Our concern is that doctors do not have to resort to a court of law every time they are faced with these kinds of difficult decisions."

In two other cases the courts have held that brain damaged babies should be allowed to die, but without laying down principles for future cases. Neil McIntosh, professor of child life and health at Edinburgh University and chairman of the British Paediatric Association's ethics committee, said that doctors tended to put very premature babies on a ventilator and review their progress later.

His committee is drawing up guidelines to help doctors in deciding whether to withdraw or withhold treatment. These are expected to be finalised within the next six months. —CLARE DYER, *legal correspondent, BMJ*

TODAY/REX FEATURES

Prevention or potential trouble?

Scottish judges say court can decide in PVS cases

Five senior judges ruled last week in Scotland's first right to die case that a single judge in the Court of Session can sanction the withdrawal of artificial feeding from a patient in the persistent vegetative state. The case of Janet Johnstone, who is 53 years old and has been in a persistent vegetative state since 1992 after an overdose of prescribed medicines, will now go back to Lord Cameron, who referred the case to the more senior judges because of its complexity and sensitivity.

The judges ruled that the court could authorise doctors to discontinue feeding, but as a civil court it could not grant the immunity from prosecution sought by the Law Hospital NHS Trust. The Lord Advocate, Lord Mackay of Drumadoon, is to issue a policy statement on criminal liability within the next few weeks.

The ruling opens the way for such cases to go to court in Scotland in the same way as they have done in England since 1992, when doctors caring for Tony Bland, a victim of the Hillsborough football stadium disaster, sought court sanction to end his life.

The decision coincided with the publication of new guidelines from a Royal College of Physicians working party to help doctors diagnose persistent vegetative state. The guidelines were prepared before the discovery this month that a patient diagnosed as having the condition for seven years was sentient and able to communicate with hospital staff.

Professor David London, the college registrar, said: "Our guidance is based on the best evidence available to us at the time and is intended to help doctors by differentiating

the clinical states in line with current knowledge. When we have seen the clinical details of this recent case, we will review the guidance."

The group prefers to use the term "permanent" rather than "persistent" vegetative state and states that it can be diagnosed when a patient has been in a vegetative state for more than a year after a head injury or for six months after brain damage from other causes. The state should be diagnosed by two independent doctors with experience in assessing disturbances of consciousness. The assessors must ask medical and other clinical staff and relatives or carers about the patient's reactions and responses. The diagnosis is based on clinical criteria, including no awareness of self or the environment, no evidence of language comprehension or expression, and no response to visual, auditory, or tactile stimuli.—CLARE DYER, *legal correspondent, BMJ*

Census shows that employment is healthier

Employed men and women in Britain had lower overall mortality rates than the rest of the population during the 1980s, according to new figures released by the Office of Population Censuses and Surveys (OPCS). The 1980s was the decade when unemployment was at its highest in Britain, peaking at more than 3 million in 1986 before beginning to decline.

By 1990 it had fallen to around 1.6 million. It rose again in the following years to reach 2·3 million in 1995. Latest figures show it at 2·2 million. The OPCS report says that it is already widely accepted that men who were unemployed in the 1971 census had 20% higher mortality rates than employed men.

There is a clear social class difference in mortality among all men of working ages, reports the OPCS. But even within each social class, mortality remained higher for men seeking work than for all men in the social class. Thus social class background was not the sole factor in raising mortality.

The report observes: "With the smaller proportion of men in employment in 1981 one might expect the workforce to retain the healthiest people. This would seem to be supported by the relatively lower standardised mortality ratios for men in employment in 1981."

In another section of the OPCS Population Trends teenage drinking is surveyed, with the finding that teenagers drink more alcohol than five years ago and that more than half of secondary school pupils have tried it. Among pupils aged 11 to 15 in England weekly alcohol intake was 6·4 units in 1994, compared with 5·4 in 1990. —CLAUDIA COURT, *BMJ*

Population Trends 83 (Spring 1996) is available from HMSO, price £11.

GP struck off for fraud in drug trials

A general practitioner in Britain has been struck off after the professional conduct committee of the General Medical Council decided that he had entered patients for paid drug trials without their consent (see p.789) Dr Geoffrey Fairhurst, 57, a former government health adviser, practised in St Helens, Merseyside. Sir Donald Irvine, president of the GMC, expressed particular concern that Dr Fairhurst had served on a research ethics committee.

Dr Fairhurst signed agreements to test various drugs including captopril, bumetanide, and lacidipine between 1988 and 1993. He was accused of forging four patients' consent forms and prescribing them drugs without telling them they were taking part in a trial. He was also charged with instructing the practice nurse to falsify reports on electrocardiograms from eight other patients who were participating in drug trials.

He was reported to the GMC by his partner Dr David Edwards after one of the patients died in an unrelated incident. Dr Fairhurst's research assistant, Debbie Beardsmore, also gave evidence against him. She said that she had once had an affair with Dr Fairhurst but denied that her testimony was motivated by bitterness.

The committee heard of acrimonious relations between Dr Fairhurst and Dr Edwards. Nicola Davies QC, for Dr Fairhurst, questioned the memory of patients who gave evidence. Dr Fairhurst claimed they were "either wrong or not telling the truth."

The full value of the drug trials to Dr Fairhurst was not disclosed, but one contract earned £15 000. Dr Edwards told the hearing: "Dr Fairhurst appeared to be carrying out his tests in treatment time. The finances from this went solely into his private company. I had access to his consulting room, which was next to mine, but his research work was in separate offices which were kept locked upstairs. Following the death of one patient, it became clear to me that patients were entered in clinical trials without informed consent."

Rosalind Foster, barrister for the GMC, said that Dr Fairhurst's actions had the potential for grave harm. "Fraud will not be tolerated by the medical profession. Colleagues must be prepared to blow the whistle when they come across it." Sir Donald said in his summing up: "All doctors are reminded of their duty to take action where they have good reason, as in this case, to believe that a colleague may be acting contrary to the standards of practice set out in the council's guidance. Only in this way can the council uphold the integrity of the profession."—OWEN DYER, *freelance journalist, London*

NHS urged to rethink children's rights

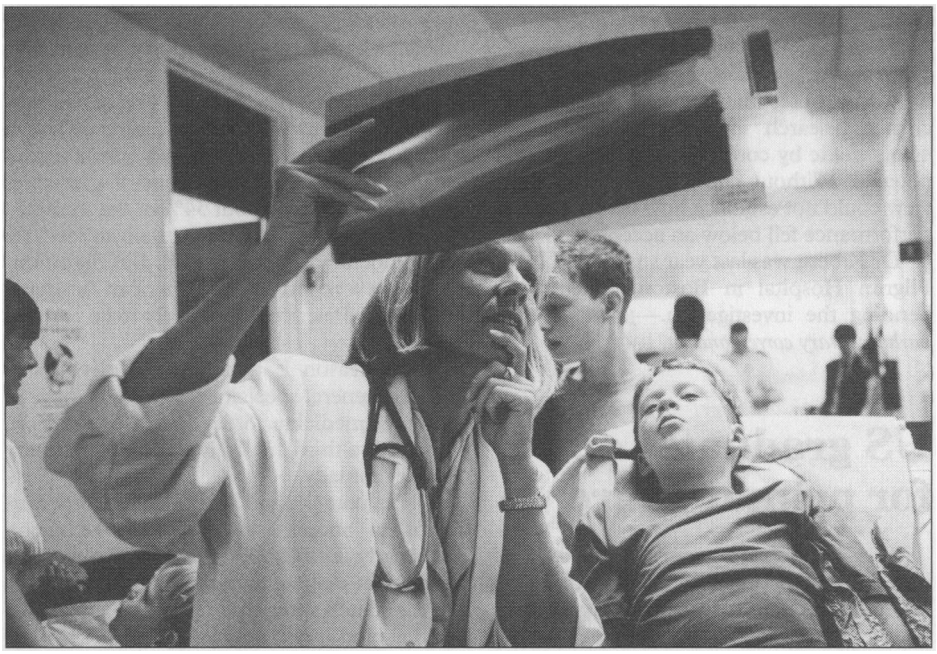
A radical reappraisal of children's right to participate in decisions about their medical treatment is needed throughout the NHS, says a report published this week.

The report, published by the Institute for Public Policy Research, acknowledges individual clinicians' excellence in including children in health care decisions. But it is critical of what it perceives as a more general trend away from child consultation towards decision making by parents or health care professionals.

"There is a tendency among health care professionals to underestimate children's ability to cope with complex and distressing

NEIL LIBBERT/NETWORK

Unemployment has deadly effects



SAM TANNER

What would you like to do about your fracture?

knowledge. The health care professional may therefore act defensively, excluding or dismissing children's views," said one of the study's authors, Dr Priscilla Alderson, senior research officer at the Institute of Education in London.

The report also calls for urgent clarification of the law regarding children's consent to medical treatment. After the 1985 Gillick ruling, which suggested that children understand many aspects of consent and that decisions should be taken with their cooperation whenever possible, several legal rulings in 1992 excluded children once more from decision making about treatment.

"We have to provide a new legal system which is practicable and workable and which supports good practice, rather than the law constantly intervening to change health care decisions," said coauthor Jonathan Montgomery, senior lecturer in law at the University of Southampton.

The study recommends an enforceable code of practice for health care professionals that would ensure that those children who want it are given information on proposed treatment and that their views are "genuinely taken into account."

"The emphasis is on partnership and participation, involving children, parents, and health care professionals from an early stage in treatment, rather than focusing on an all or nothing question later on," Mr Montgomery said. The code would promote the participation of children of all abilities in decision making, even if they cannot, or choose not to, take responsibility for decisions.

The report also recommends a change in the law to enable children to consent to, or refuse, treatment if they are competent to understand the treatment and its consequences.

A further change of emphasis is recommended as a future procedural guideline—that all children aged over 5 should be presumed competent unless expressly considered otherwise. Even if young children are unable to make a decision with serious consequences, they may be well equipped to make a minor decision concerning their proposed medical treatment.—ALISON BOULTON, *freelance journalist, London*

Health Care Choices: Making Decisions with Children is available from the Institute for Public Policy Research, 30-32 Southampton Street, London WC2E 7RA, price £7.50 plus 50p p&p.

NHS The Patient's Charter: Services for Children and Young People is available from the Health Literature Line (tel: 0800 555777).

Russian life expectancy rises

Life expectancy for both men and women in Russia increased by a year in 1995 after a 5% drop in the number of deaths. But the one year rise from 57 years to 58 years for men and 71 years to 72 years for women does not, say experts, signify an overall improvement in the nation's health.

On the contrary, health is still declining. Deaths from cancer and circulatory diseases were 5% and 12% higher respectively in 1995 compared with 1987.

According to Sergei Zakharov of the Centre for Human Demography and Ecology, the drop in the number of deaths from 2 301 400 in 1994 to 2 197 400 in 1995 is largely explained by an unexpected fall in the number of fatal accidents related to alcohol consumption. These rate as the second major cause of death in Russia, after diseases of the circulatory system.

The country's accidental death rate, which includes alcohol poisoning, has risen steadily from 8·7 per 100 000 in 1989 to 47·7 in 1994. The number fell by 25% in 1995, accounting for most of the rise in average life expectancy in Russia, but Zakharov says that so far there are no explanations.

Russia is also notable for the discrepancy between the life expectancy of its men and women. According to United Nations data, life expectancy for Russian men ranks 133rd in the world, whereas for Russian women it hovers around 90th place.—MIRANDA INGRAM, *Moscow bureau chief, European*

Campaign aims to make the English more active

The Health Education Authority has launched a national physical activity campaign in England to try to improve the nation's health. The campaign, Active for Life, advocates regular, moderate activity and promotes the idea that any activity is better than none.

The £9m campaign, which will run over three years, reflects the results of recent American research suggesting that cardiovascular benefits come not only from vigorous exercise but also from moderate activity such as brisk walking and cycling—which also prevents or helps becoming overweight and other problems. This exercise should be taken for half an hour three times a week.

A quarter of the population, according to a Health Education Authority survey that will be repeated, have no physical activity that could benefit health and many (60% of men and 70% of women) have insufficient activity—even though most people believe that exercise would be good for them.

The campaign suggests realistic activities: walking or cycling at least part of the way to work or school, for example; dancing; and walking upstairs instead of taking a lift. "We want to help people to lead a more active life—not to tell them to take more exercise," said Nick Cavill, the Health Education Authority's physical activity manager. —DAPHNE GLOAG, *freelance journalist, London*

Strategy Statement on Physical Activity and the report of the Physical Activity Task Force are available from the Department of Health Press Office, Richmond House, 79 Whitehall, London SW1A 2NS.

Locum's errors prompt review

Hospitals in Britain have been advised to apply "more robust standards" when appointing locums after investigations into numerous diagnostic errors by Dr Samuel Kiberu while he was working as a locum consultant histopathologist at two hospitals, in Grantham and Bassetlaw, between 1991 and 1993. The case may also result in new research into error rates in histopathology, because of a lack of comparative data.

Dr Kiberu, who trained in Dar es Salaam, was found to have made 392 errors in 2721 cases at Grantham and 139 errors in 1509

cases at Bassetlaw (*BMJ* 1995;311:213). Last week's final report to the NHS Executive concerned the process of his appointment and the discovery of errors in his work. The report has been referred to the General Medical Council.

Although the review found examples of administrative and procedural weaknesses, it concludes that Dr Kiberu might have been appointed as a locum consultant irrespective of the shortcomings. Those responsible for his appointment were faced with the need to strike an appropriate balance between maintenance of clinical services and proper appointments processes.

The report suggests that the balance may need to be shifted towards higher standards in appointing locums, even at the risk of short term disruption to services. The greatest safeguard, it adds, is to reduce the overall reliance on locum doctors.

The report commends the actions of Dr David Clark, who followed Dr Kiberu as consultant histopathologist at Grantham Hospital and discovered the errors. Had Dr Clark failed to act in the prompt manner that he did, the extent of the errors in Dr Kiberu's work would have remained undiscovered for longer, the report states.

Accepting that "it is inevitable that all pathologists will sometimes make errors," the report notes that there has been no conclusive research into the normal rate of errors made by consultants of average competence. Without comparative data, thereview could not establish how far Dr Kiberu's performance fell below an acceptable level.

Dr Kiberu was last year suspended by the Pilgrim Hospital in Boston, Lincolnshire, pending the investigation.—JOHN WARDEN, *parliamentary correspondent, BMJ*

US graduates opt for primary care

For the fourth year in a row, graduates of US medical schools are picking primary care as their most popular career choice. Final year medical students are asked to rank their choices for postgraduate education specialties and programmes. Those choices are placed into a computer, and last week students were handed envelopes telling them whether they had the job that they wanted.

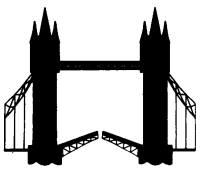
Similarly, other general specialties saw continued growth. Internal medicine saw a 2·9% growth over 1995 and paediatrics a 6·1% growth. The three general specialties together attracted about 54% of the students. US policy makers hope eventually to see 50% of all doctors in primary care. But that number, says a report by the American Academy of Family Practice, is not likely to be reached soon.

The reason is that many students who choose general specialties, especially those in internal medicine, often specialise later on. Just over a third are likely to practise primary care eventually.

This year showed a 50% drop in applications to anaesthesiology and a reduction of nearly a third in students looking for careers in diagnostic radiology. "The results of the match show that US medical students understand the changing needs of the nation's evolving health care system," said Dr Jordan Cohen, president of the Association of American Medical Colleges.—JOHN ROBERTS, *North American editor, BMJ*

Focus: London

Another task for harrassed doctors



Stress, a BMA colleague remarked this week, is no longer news. Everyone, he said—policemen, teachers, farmers—suffered from it and increasingly were establishing services to help cope with it. Doctors are no exception, and the BMA will itself launch its stress helpline for doctors in a couple of weeks' time. In the meantime a report from the Nuffield Provincial Hospitals Trust on taking care of doctors' health reminds us why it's necessary.

The Nuffield trust is one of those useful, privately funded bodies that produce well researched reports and do good quietly behind the scenes, often in areas which don't attract much other funding or attention. This time it brought together a working group to tackle the twin problems that underlie the issue of reducing avoidable stress and improving services for doctors who fall ill: doctors' attitudes towards their own ill health (they often fail to acknowledge it) and the inadequacies of existing mechanisms to help ill doctors.

The report draws on a substantial body of evidence over the years that shows high levels of stress and mental illness among doctors; this evidence, it concludes, reflects the longstanding failure of the NHS to respond to the needs of its workforce. In other words, it blames the way clinical services are organised: the long hours, high expectations, lack of support, and, recently, the increased demands of the reformed NHS. As last week's editorial by Chambers and Maxwell advocated, "fix the job, not the doctors" (23 March, p 722).

The report also discusses the shortcomings of existing mechanisms for helping doctors with problems. Occupational health services within the NHS are poorly developed and may not be seen as discreet enough. The "three wise men" procedure is a very British mechanism which relies absolutely on discretion, and wisdom. If the three wise men, and particularly their chairman, are wise enough then it can be an effective mechanism for temporarily removing a sick doctor from practice and getting him or her treated. However, as the Nuffield report points out, the secrecy that characterises the procedure can undermine its effectiveness because people don't know how it works. Moreover, the system applies only to hospital doctors and is less effective now that district and regional directors of public health no longer have the power to provide locum cover at the request of the wise men.

A similar ignorance shrouds the National Counselling Service for Sick Doctors, set up in 1985 to provide a confidential counselling service and persuade doctors who need help to seek treatment. There is less ignorance about the GMC's health procedures, which are reported to work well and sensitively but suffer from their association with the council's disciplinary role.

The working party clearly thinks that there are probably enough sources of help for doctors. What is needed is better knowledge of them and more willingness to use them, together with a monitoring and coordinating mechanism. This, it suggests, should take the form of a committee operating at subregional level and initially chaired by the regional postgraduate dean. The committee would be responsible for reviewing what services were available and working to improve them and access to them, but it would also be responsible for reviewing working conditions and recommending improvements. In addition, a single named individual in each locality should act as the first point of contact for any doctor seeking confidential advice about either their own or a colleague's problems.. The committees should, the report argues, be funded directly by the NHS Executive.

That is a fair call on NHS funds: that this report should be written almost 50 years after the start of the NHS is an indictment of the service and its employment practices. But the report also represents an implicit criticism of doctors themselves: conditions in the NHS may have recently become more stressful (as doctors feel they have less control over them), but for many of those 50 years the organisation of clinical work was squarely in the hands of the medical profession itself.—JANE SMITH, *BMJ*